**Section 1: Patient Safety Improvement Act of 2016**

**Section 2: Findings**

**Section 3: Improving Data Reliability and Surveillance**

a. GAO study on data validation strategies.
Require a GAO study on the actions the Centers for Disease Control and Prevention (CDC) and state and local departments of health have taken to assure completeness and accuracy of hospital-reported National Healthcare Safety Network (NHSN) surveillance data. The report shall assess the types of external and internal validation strategies that are conducted, the frequency with which such validation strategies are utilized, and recommendations for improving NHSN data quality and federal, state, and facility-level validation efforts.

b. Data reliability framework.
Following the GAO report, CDC, in collaboration with AHRQ and relevant stakeholders, shall develop a framework to improve the consistency and reliability of hospital data on healthcare-associated infections that is submitted to NHSN. The framework shall address issues identified in the GAO study authorized in (a), propose data validation and reliability methodologies, and assess the cost to implement the proposed methodologies. Authorize such sums necessary.

c. Data collection pilot program.
(1) AHRQ, in collaboration with CDC, shall convene stakeholders to identify best practices and approaches for the collection and reporting of data on healthcare-associated infections to NHSN by long-term care facilities, ambulatory surgical centers, and dialysis facilities.

(2) Following the stakeholder meeting, AHRQ shall conduct a pilot program to test the best practices and approaches for reporting healthcare-associated infections data to NHSN by select long-term care, ambulatory surgical centers, and dialysis facilities. Where applicable, pilot participants shall incorporate applicable data validation methodologies and other recommendations identified in the framework in (b). AHRQ shall submit a report to Congress and HHS on the lessons learned in the pilot programs and recommended surveillance methods applicable to each care setting.

Authorize such sums necessary. Funding can be used for the purchase of software and technology that supports data collection and reporting.

**Section 4: Aligning Quality Measures**

a. Aligning HAI Quality Measures.
Not later than one year after the date of enactment, the Secretary shall solicit input from CDC, AHRQ, CMS, and stakeholders on which definitions of HAI quality measures for hospitals, LTCFs, ASCs, and dialysis centers should be aligned across federal agencies and state quality reporting and payment programs. Using this input, the Secretary will submit a report to Congress identifying priority measures for standardization and alignment, the programs in which these measures are used, and recommendations on how to implement alignment of these measures.

**Section 5: Reducing Healthcare-Associated Infections**

a. Grant program to reduce healthcare-associated infections.
The Secretary shall award competitive grants to support State-based collaboratives in implementing evidence-based, regional approaches to infection prevention, control, and reporting. Priority is given to applicants that collaborate with multiple stakeholders across a region or state. Authorize such sums necessary.

b. Improving provider communication regarding patient infections in Medicare and Medicaid.
Require as a condition of Medicare and Medicaid participation that hospitals transmit information about infections or colonizations that an individual receiving treatment acquires during the course of that treatment to not later than 24 hours upon receipt of the culture to: (1) the individual; (2) health care providers receiving those patients upon discharge or transfer; and (3) the individual's primary care provider, if known.

The transmitted information must contain the information fields included in CDC's Inter-Facility Infection Control Transfer Form. When practical, this information should be transmitted electronically. The Secretary, in collaboration with CDC, shall issue an electronic version of this form that may be used to satisfy the condition of participation.

**Section 6: Strengthening Antibiotic Stewardship**

a. Grant program for state antibiotic stewardship action plans.
The Secretary, acting through CDC, shall award grants to States for the development of state antibiotic stewardship action plans to promote antibiotic stewardship and prevent the spread of antimicrobial-resistant bacteria across health care settings. The state plans must focus on collaboration across acute and ambulatory care settings, and be led by an infectious-disease trained physician or pharmacist with expertise in infectious diseases. Authorize such sums necessary.

b. Advancing hospital reporting on antibiotic use and antimicrobial resistance.
Not later than January 1, 2018, CMS shall require acute care hospitals to collect data on antibiotic use and antimicrobial resistance using the NHSN's Antimicrobial Use and Resistance Module as part of the Hospital Inpatient Quality Reporting Program.

c. Information related to antibiotics and antibiotic resistance.
(1) CDC shall annually prepare and issue a report on aggregate national and regional trends of antibiotic use and bacterial resistance in humans to antibacterial drugs, including the identity of the 10 States with the highest aggregate number of prescriptions for antibiotics.

(2) Beginning in 2019, CDC shall conduct at least one antibiotic stewardship workshop annually in a state identified in its report to Congress. The workshop shall identify regional strategies to support collaboration across the care continuum to promote antibiotic stewardship. Authorize such sums necessary.

**Section 7: Other Improvements**

a. Continuing education on infection control and patient safety.
The Secretary shall establish a program to provide incentives to State medical boards that require licensed health care professionals to complete accredited coursework or training in infection control or other patient safety topics as a condition of receiving a renewed license to practice in the State. Authorize such sums necessary.

b. Engaging hospital leadership in patient safety.
Require as a condition of Medicare and Medicaid participation that new members of hospital boards receive training within six months of joining a board on patient safety topics relevant to hospital settings. The Secretary shall establish criteria through an NPRM specifying the number of hours and type of training that satisfy this condition of participation.

c. Improvements to the Patient Safety and Quality Improvement Act of 2005.
This subsection would make four modifications to the Patient Safety Organization (PSO) program and AHRQ's Network of Patient Safety Databases:
    (1) Authorize PSOs to collect information directly reported by patients on patient safety incidents and unsafe conditions. Clarifies that such information shall not be deemed "identifiable patient safety work product."
    (2) Require PSOs to submit all patient safety work product – including patient-reported information – to the network of patient safety databases. PSOs must ensure that patient-reported information is de-identified prior to submitting to the network.
    (3) Require AHRQ to conduct research on best practices for patient-safety organizations to engage patients in reporting on patient safety incidents and for the collection of patient-reported information.
    (4) Require AHRQ to establish a single access point on AHRQ's website that may be accessed by the public to obtain patient safety data that has been aggregated by the network of patient safety databases.

Authorize such sums necessary.